Exhibit A

Johnson & Johnson Group Health Plan
(As Amended and Restated Effective January 1, 2023)

CERTIFICATION OF AMENDMENT AND RESTATEMENT
OF THE
JOHNSON & JOHNSON GROUP HEALTH PLAN

Effective as of January 1, 2023, the attached Johnson & Johnson Group Health Plan is hereby amended and restated.

ON BEHALF OF THE
PENSION AND BENEFITS COMMITTEE
OF JOHNSON & JOHNSON

Date: 12/29/22

Douglas Grant
DOUGLAS GRANT
Member

THE JOHNSON & JOHNSON

GROUP HEALTH PLAN

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THE JOHNSON & JOHNSON GROUP HEALTH PLAN
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ARTICLE I
NAME, PURPOSE, AND EFFECTIVE DATE

1.01 Name.

This plan is designated as The Johnson & Johnson Group Health Plan (the "Plan").

1.02 Purpose.

The purpose of this Plan is to provide specified health-care related benefits to certain eligible active, former, and retired Employees of Johnson & Johnson and affiliated companies and their Dependents.

1.03 Plan Document.

The official Plan document shall consist of this document (the "Umbrella Plan Document") and the Component Summary Plan Descriptions (SPDs) and Insurance Contracts, each of which is designated on Schedule A hereto and incorporated herein by reference.

1.04 Effective Date.

This amendment and restatement of the Plan is effective as of January 1, 2023.

ARTICLE II
DEFINITIONS AND CONSTRUCTION

2.01 Definitions.

The words and phrases used in this document and/or a Component SPD shall have the meanings set forth below, unless otherwise specifically provided or unless a different meaning is required by the context. Any rules set forth in the following definitions shall apply.

(a) **"COBRA"** means the Consolidated Omnibus Budget Reconciliation Act of 1985, as in effect and as amended from time to time.

(b) **"COBRA Beneficiary"** means any individual who qualifies under COBRA (or state law) for statutory continuation coverage under this Plan solely in accordance with the terms set forth in the applicable Component SPD.

(c) **"Code"** means the Internal Revenue Code of 1986, as in effect and as amended from time to time.

(d) **"Company"** means the Sponsor and the Participating Affiliates.

(e) **"Covered Individual"** means a Participant or a Participant's Dependent who is covered under the Plan.

(f) **"Component SPD"** means a summary plan description that is designated as such on Schedule A hereto. Each Component SPD shall set forth the terms and conditions of one of the component plans that comprise the Johnson & Johnson Group Health Plan, as described elsewhere in this document. Each Component SPD shall specifically define the Eligible Employees to whom that component plan applies and the applicable terms of coverage under that component plan. Each Component SPD shall be deemed to incorporate any materials specifically referenced therein and any applicable Summary of Material Modifications. Each of the Component SPDs is incorporated by reference herein and made a part of the Plan.

(g) **"Dependent"** means any of the following individuals who meets the definition of Dependent as set forth in the applicable Component SPD: (i) the legally married spouse of an Eligible Employee, Former Employee, Retiree, or (if the spouse is not a COBRA Beneficiary), COBRA Beneficiary; (ii) a child of an Eligible Employee, Former Employee, Retiree, (if the child is not a COBRA Beneficiary) COBRA Beneficiary or spousal Surviving Beneficiary; or (iii) a child of a deceased Employee, Former Employee, or Retiree other than the eldest such child. "Dependent" shall also include a "partner" of an Eligible Employee or a child of such partner as set forth in the applicable Component SPD. Partners of Retirees and Former Employees shall not be eligible to participate in the Plan except as specified in the applicable Component SPD.

(h) **"Eligible Employee"** means any Employee who is eligible to participate in the Plan in accordance with the rules set forth in the applicable Component SPD. Except as expressly provided in a Component SPD, no "leased employee," as defined in section 414(n) of the Code, or other individual engaged by the Company through a staffing firm or similar entity shall be an Eligible Employee.

(i) **"Eligible Participant"** means an Eligible Employee, Former Employee, Retiree, COBRA Beneficiary, or Surviving Beneficiary.

(j) **"Employee"** means an individual who is employed by the Company.

(k) **"Former Employee"** means an individual who has terminated from employment with the Company and who is eligible to participate in the Plan in accordance with the rules set forth in the applicable Component SPD. Except as expressly provided in a Component SPD, no "leased employee," as defined in section 414(n) of the Code, or other individual engaged by the Company through a staffing firm or similar entity shall be a Former Employee.

(l) **"HIPAA"** means the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations thereunder.

(m) **"Insurance Contract"** means a contract with one or more of the Insurers which contract may be (i) an insured HMO contract, or other group health insurance or group health coverage contract designated on Schedule A, or (ii) an agreement with respect to one or more Johnson & Johnson Policies and Procedures documents (with Comparison Charts) on Schedule A, between the Sponsor and the Insurer, as amended from time to time, or any successor thereto. The Insurance Contracts are hereby incorporated by reference into, and made a part of, the Plan.

(n) **"Insurer"** means any insurance company that provides group insurance coverage, including a risk-assuming HMO that is identified under "Insurance Contracts" in Schedule A hereto.

(o) **"Participant"** means any individual who is an Eligible Employee, Former Employee, Retiree, COBRA Beneficiary, or Surviving Beneficiary who is participating in the Plan in accordance with Article III hereof.

(p) **"Participating Affiliate"** means an Affiliate whose employees have been approved for integration into the Plan by the Sponsor. Such entity shall become a Participating Affiliate as of the date its participation in the Plan begins and shall cease to be a Participating Affiliate on the date as of which it or the Sponsor determines its participation shall terminate. For purposes of clarity and without limitation, any Affiliate identified in Schedule B shall not be a Participating Affiliate. **"Affiliate"** means any entity that, together with the Sponsor, constitutes a group of trades or businesses under common control, a controlled group of corporations, or an affiliated service group as defined in Sections 414(b), (c), and (m) of the Code, respectively, or that must otherwise be aggregated with the

Sponsor under Section 414(o) of the Code. **"Controlled Group"** means the Sponsor and all of its Affiliates.

(q) **"Pension and Benefits Committee"** means the Pension and Benefits Committee of Johnson & Johnson.

(r) **"Plan"** means The Johnson & Johnson Group Health Plan, as herein set forth, and as amended from time to time, together with the attachments hereto and materials incorporated by reference herein and/or, as applicable in context, the relevant component plan, as described in Section 8.13.

(s) **"Plan Administrator"** means the administrator of the Plan, for purposes of the Employee Retirement Income Security Act of 1974, as amended, and the purposes set forth herein, as designated in Section 7.01.

(t) **"Retiree"** means an individual who is retired from employment with the Company and who is eligible to participate in the Plan in accordance with the rules set forth in the applicable Component SPD.

(u) **"Service Administrator"** means an organization designated by or contracting with the Sponsor for purposes of providing administrative services under the Plan, as described in Section 7.03.

(v) **"Sponsor"** means Johnson & Johnson, a corporation organized under the laws of the State of New Jersey, which is the sponsor of the Johnson & Johnson Group Health Plan and the component plans that comprise the Johnson & Johnson Group Health Plan for purposes of the Employee Retirement Income Security Act of 1974, as amended, and the purposes set forth in this Plan.

(w) **"Surviving Beneficiary"** means a surviving spouse or, where there is no surviving spouse, the eldest surviving child of a deceased Employee, Former Employee, or Retiree, which spouse or child remains eligible to enroll for coverage in accordance with the terms of the applicable Component SPD. "Surviving Beneficiary" also shall include a surviving partner of a deceased Employee, Former Employee or Retiree, or the eldest surviving child of such partner, as set forth in the applicable Component SPD. To be regarded as a Surviving Beneficiary, a surviving spouse, partner, child or partner's child must actually have the right to make an enrollment election under the Plan and not merely be eligible to be enrolled by another survivor of the deceased Employee, Former Employee, or Retiree.

(x) **"Trust"** means the trust fund or funds established by the Sponsor for purposes of providing the benefits payable under the Plan and any other employee welfare benefit plan that the Sponsor may maintain.

(y) **"Trustee"** means the bank or trust company approved by the Sponsor to be the administrator of the Trust.

(z) **"Trust Fund"** means a fund within the Trust established by the Sponsor for purposes of providing benefits and defraying administrative expenses under the Plan.

(aa) **"Workforce"** means workforce within the meaning of the administrative simplification provisions of the HIPAA, including employees, volunteers, and trainees of the Company; other persons whose conduct, in the performance of work for the Company, is within the direct control of the Company, whether or not they are paid by the Company; and persons who are assigned under a contract to perform a substantial proportion of their activities for the Company at work stations on the Company's premises.

2.02 Gender and Number.

Masculine pronouns shall refer to both males and females. Singular or plural words shall be construed to refer to the plural or singular, respectively, when appropriate.

ARTICLE III
ELIGIBILITY AND COVERAGE

3.01 Eligibility for Participation.

An individual who is an Eligible Participant shall be eligible to become a Participant in the Plan as of the first day on which the individual satisfies the eligibility requirements specified in the applicable Component SPD and, where insured, Insurance Contract. Dependents of an Eligible Participant shall be eligible to participate in accordance with the provisions of the applicable Component SPD. The Component SPDs shall identify the Employees, Former Employees, Retirees, COBRA Beneficiaries and Surviving Beneficiaries who are eligible to participate in the Plan. For purposes of determining the eligibility of any individual for coverage under the Plan, the individual's status as an Employee, Former Employee, Retiree, COBRA Beneficiary, or Surviving Beneficiary, leased employee, or any other classification of individuals shall be determined by the Company in accordance with the terms of the applicable Component SPD and the Company's own policies, practices and classifications, regardless of the treatment of the individual for any purpose under the Code, the common law, or any other source of legal authority and regardless of any determination of such status, whether prospective or retroactive, as to the individual's status by any governmental agency or other governmental entity.

The Company may identify additional groups of employees or former employees on a periodic basis that may be added to or deleted from coverage under the Plan. In such event, the Company shall so notify the applicable Service Administrator and shall identify the affected individuals in the applicable Component SPD.

3.02 Benefit Options and Levels of Coverage.

The benefit options and levels of coverage available to Participants under the Plan shall be as set forth in the Component SPDs and, as applicable, Insurance Contracts. The terms and conditions governing each benefit option and level of coverage, including, but not limited to, the form, amount, and duration of benefits, the availability of coverage for Dependents, the coordination of benefits with other group medical plans, the right to pursue inappropriate or excess payments and to pursue fraud, the treatment of qualified medical child support orders, and the amount and payment of any contributions or premiums shall be as set forth in the applicable Component SPD, the materials referenced therein, and, if applicable, the relevant Insurance Contract.

3.03 Procedure for and Effect of Enrolling in the Plan.

An Eligible Participant may enroll in the Plan and become a Participant at the times and in accordance with the procedures established from time to time by the Plan Administrator. Each applicable Component SPD and, as applicable, Insurance Contract shall set forth the procedures for initial enrollment, annual enrollment, and any permitted changes or modifications to coverage for all Eligible Participants and their Dependents, as well as the provision for Dependent eligibility verification. Except as set forth in the applicable Component SPD, a Participant's Dependents may be enrolled only for the same coverage that applies to the Participant. By enrolling in and becoming a Participant in the Plan, each Eligible Participant and his Dependents

shall, for all purposes, be deemed to have assented to the provisions of the Plan and all amendments thereto.

3.04 Termination of Coverage.

A Participant's coverage, including coverage, if any, for Dependents, shall terminate in accordance with the terms of the applicable Component SPD, and, if applicable, with respect to the coverage offered by an Insurer, the relevant Insurance Contract.

3.05 Waiver and Default.

An Eligible Participant may waive coverage under the Plan for himself and/or his Dependents, if any, to the extent permitted by, and in accordance with, the procedures specified in the applicable Component SPD. An Eligible Participant who fails to elect or waive coverage under the Plan for himself and/or his Dependents shall be provided with the default coverage, if any, specified in the applicable Component SPD.

3.06 Limitations.

Notwithstanding any other provision of the Plan, if the Plan Administrator determines at any time that the Plan may fail any nondiscrimination requirement imposed on the Plan by the Code, or any other provisions of applicable law, the Plan Administrator may take such action as is necessary or appropriate, in the judgment of the Plan Administrator, to assure compliance with the applicable requirement. To the extent that coverage is provided under an insured HMO or other insured option, no benefits shall be paid unless they are provided under the applicable Insurance Contract.

ARTICLE IV
CONTRIBUTIONS, FUNDING, AND PAYMENT OF BENEFITS

4.01 Participant Contributions.

The Sponsor shall establish each year the amount of Participant contributions that may be required under the Plan for each benefit option and level of coverage, as well as any other cost-sharing measures that apply, including, but not limited to, deductibles, copayments, coinsurance percentages, out-of-pocket maximums, and lifetime maximums. The amount of any Participant contributions and cost sharing shall be set forth in each applicable Component SPD and/or annual enrollment materials.

Participants may make contributions to such benefits by salary reduction elections under the Sponsor's flexible benefits plan, or by any other method set forth in the applicable Component SPD or prescribed by the Plan Administrator.

4.02 Funding and Establishment of Trust.

Benefits under this Plan shall be funded through contributions made by the Company and by enrolled Participants. All contributions to the Plan by the Company and Participants shall be transferred to one or more Trust Funds that shall be established by the Sponsor or, as the Plan Administrator determines, in its discretion, paid directly as premiums to an Insurer. The Sponsor shall establish one or more Trust Funds with one or more banks or trust companies. The Sponsor shall appoint one or more Trustees with respect to each Trust Fund and may, at its discretion, remove any Trustee appointed by it and appoint as successor any other individual bank or trust company that it determines to have appropriate qualifications.

4.03 Payment of Benefits and Expenses.

a. Insured Benefits. With respect to any benefits that are provided through an Insurance Contract, the Company shall provide for such benefits through the payment of premiums from the Trust Funds (or at the Plan Administrator's discretion from funds not placed in the Trust) to the applicable Insurer, and neither the Company nor the Trust shall have any other liability with respect to such benefits.

b. Self-Insured Benefits. Some or all of the benefits under the Plan may be provided by the Company on a self-insured basis. All self-insured benefits shall be paid by the Company from the Trust Funds in accordance with the terms of the applicable Component SPD.

c. Expenses of the Plan. As directed by the Plan Administrator, the Trustee shall also pay out of the Trust Funds assets expenses of administration of the Plan including fees and expenses of the Service Administrators and expenses of other parties of interest reasonably chargeable to the Plan to the extent permitted by the law. The Plan Administrator may alternatively pay such expenses out of the general assets of the Sponsor

d. Limitation of Benefits. Benefits under the Plan shall be paid to the extent assets are available in the Trust Funds or, as applicable, provided by an Insurer under an Insurance

Contract. The Employer shall not be obligated to pay benefits under the Plan in excess of the amounts available under the Trust Funds or, as applicable, provided through an Insurance Contract.

e. Trust Funds. All contributions to the Trust for the Plan shall be placed in one or more Trust Funds. The Trust Funds shall be maintained and used solely for the payment of benefits and administrative expenses under the Plan. To the extent that the Trust includes funds for the payment of benefits and administrative expenses under other welfare benefit plans, such amounts shall be placed and held in separate funds and shall not be used for purposes of the Plan. Amounts in the Trust Funds shall, at all times, be accounted for separately from any other funds held in the Trust.

4.04 Payment to Participant or Health Care Provider.

Except as otherwise provided in Section 4.05 and 8.12, benefit payments under this Plan shall be made to the Covered Individual or to a health care provider in accordance with the terms of the applicable Component SPD and, as applicable, Insurance Contract**.**

4.05 Incompetence.

If the Plan Administrator determines that a Covered Individual is not competent, benefit payments may be made to the court-appointed legal guardian of the Covered Individual, to an individual who has become the legal guardian of the Covered Individual by operation of state law, or to another individual whom the Plan Administrator determines to be entitled to receive such payments on behalf of the Covered Individual. Such payments shall, to the extent thereof, discharge all liability of the Company.

4.06 No Duplicate Payments/Recovery of Excess Payments.

If a payment of benefits under the Plan is made to a third party whom the Plan Administrator has determined to be entitled to receive such payment on behalf of a Covered Individual, the Plan shall be relieved, to the fullest extent permitted by law, of any obligation to make a duplicate payment to or on behalf of such Covered Individual. If a payment of benefits under the Plan is made to a Covered Individual, the Plan shall be relieved, to the fullest extent permitted by law, of any obligation to make a duplicate payment on behalf of that Covered Individual to a third party. It is a Covered Individual's responsibility to pay providers for service and supplies that the Covered Individual receives. If any benefit payment is made erroneously, in duplication, or in excess of the amount appropriately payable under a Component SPD or Insurance Contract, the Covered Individual, or the Participant or third party recipient of payment with respect to such Covered Individual shall be responsible for repaying such amount in such manner as the Plan Administrator prescribes.

ARTICLE V
STATUTORY CONTINUATION COVERAGE

5.01 Statutory Continuation Coverage.

Covered Individuals shall be eligible for statutory continuation coverage under the Plan (if at all) solely in accordance with the terms set forth in the applicable Component SPD. With respect to insured coverage only, a Covered Individual's right, if any, to convert to individual coverage shall be determined by the terms of the applicable Insurance Contract. No conversion rights are available under the Plan with respect to any self-insured coverage.

ARTICLE VI
CLAIMS AND APPEALS

6.01 Procedures for Claims and Appeals.

To be entitled to payment of any benefits under the Plan, a Covered Individual must submit all claims for benefits under the Plan and all appeals of claims that have been denied to the appropriate Service Administrator in accordance with the procedures established by the Sponsor and set forth in the applicable Component SPD or Insurance Contract.

6.02 Limitations on Legal Action.

A Covered Individual must pursue all claim and appeal rights available under the Plan (other than any voluntary appeals) before seeking any other legal recourse. Any legal action under the Plan with respect to a denied claim must be initiated within one year of the date that the final appeal is denied or, if shorter, within the applicable statute of limitations.

ARTICLE VII
ADMINISTRATION

7.01 Plan Administrator.

The Pension and Benefits Committee shall administer the Plan and shall be the named fiduciary and Plan Administrator. The Plan Administrator may delegate any of its or other's fiduciary or administrative responsibilities (other than the responsibility of Trustee) to other fiduciaries and administrators. The Plan Administrator may allocate any such fiduciary responsibility, which shall be exercisable severally and not jointly with each named fiduciary's responsibilities being limited to the specific area of responsibility set forth below, or as the Plan Administrator may further allocate and may (i) designate persons or entities other than named fiduciaries to carry out fiduciary and administrative responsibilities (other than Trustee's responsibilities) under the Plan; (ii) employ or contract with one or more persons or entities to render advice and counsel with respect to any responsibility under the Plan; and (iii) engage an independent public accountant on behalf of the Participants to conduct an annual examination of the books and records of the Company in respect of the Plan and on the basis of such examination make such report as the fiduciaries severally request. When acting on the Plan or Plan Administrator's behalf, the Sponsor may also delegate and allocate the Plan Administrator's responsibilities with the same effect as the Plan Administrator's delegation and allocation of such responsibilities. Any person or group of persons (except Trustees) may serve in more than one fiduciary capacity or administrative capacity with respect to the Plan. To the extent permitted by the Plan Administrator, any fiduciary under the Plan, other than the Plan Administrator, may delegate and allocate its responsibility.

Any action by the Plan Administrator assigning any of the Plan Administrator's responsibilities to persons who are all members of the Pension and Benefits Committee or the Company's Workforce shall not constitute an allocation of the Plan Administrator's responsibility but rather shall be treated as the manner in which the Plan Administrator has determined to discharge its responsibilities with respect to the Plan.

To the extent that any of the Plan Administrator's responsibilities have been delegated, to a Service Administrator under Section 7.03 or otherwise, references in the Plan to "Plan Administrator" shall be deemed to refer to the designee who has been delegated such responsibilities.

7.02 Trustee.

The Trustee shall have the authority under the Plan (i) to receive contributions, (ii) hold, manage, invest, and reinvest Plan funds, to the extent responsibility is not retained by the Plan or assigned to an investment manager (which powers may be so retained or assigned notwithstanding anything in Section 7.01), and (iii) upon appropriate direction pay out funds for claims and expenses.

7.03 Service Administrator.

The Sponsor, acting on its own behalf and/or on behalf of the Plan and Plan Administrator, may designate or contract with one or more Service Administrators for the performance of

administrative responsibilities with respect to the Plan, including, without limitation, claims processing and benefit payment, medical (including mental health/substance abuse) case management, disease management, network management, utilization management, utilization review, precertification, and other administrative services for the Plan. A Service Administrator may have responsibility for only components of the above services.

7.04 Discretionary Authority.

In carrying out their respective responsibilities under the Plan, the Plan Administrator, any Service Administrator and other Plan fiduciaries shall have discretionary authority to (i) interpret the terms of the Plan, including the power to remedy possible ambiguities, inconsistencies, or omissions; (ii) determine eligibility for benefits pursuant to the terms of the Plan, as well as the benefits to be provided, including the amount of such benefits; (iii) make any factual determinations; (iv) adopt rules for the administration of the Plan; and (v) take any other actions necessary or appropriate for the effective administration of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be conclusive and be given full force and effect, subject to any right to appeal the interpretation or determination as set forth in the applicable Component SPD or Insurance Contract. No determination of the Plan Administrator, any Service Administrator or other Plan fiduciary in one case shall create a bias or retroactive adjustment in any other case.

7.05 Records of Administration.

Records of administration of the Plan shall be kept, and Participants may ordinarily examine records pertaining directly to them. Records shall be made available in all circumstances required by applicable law, but may be withheld when prepared in anticipation of litigation and in other circumstances as permitted by applicable law.

7.06 Limitation of Liability.

Neither the Plan Administrator nor the Company or any member of its Workforce shall be liable for any loss due to its (or his or her) error or omission in administration of the Plan unless the loss is due to the failure of the Plan Administrator, the Company, or such member of the Workforce to exercise the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims.

7.07 Indemnification.

The Company shall indemnify each officer, director, employee or other member of the Workforce of the Company for all expenses (other than amounts paid in settlement to which the Company does not consent) reasonably incurred by him in connection with any action to which he may be party by reason of his performance of administrative functions and duties under the Plan, except in reaction to matters as to which he shall be adjudged in such action to be personally guilty of willful misconduct in the performance of his duties. The foregoing rights to indemnification shall be in addition to such other rights as the individual may enjoy as a matter of law or by reason of insurance coverage of any kind. Rights granted hereunder shall be in addition to and not in lieu of any rights to indemnification to which the individual may be entitled pursuant to the Sponsor's by-laws.

ARTICLE VIII
GENERAL PROVISIONS

8.01 Amendment and Termination.

The Sponsor reserves the right to amend, modify, revoke, or terminate the Plan, in whole or in part, at any time with respect to any individual or group covered by the Plan, including without limitation any current or future retirees. Any such amendment, modification, revocation, or termination of the Plan shall be made by or pursuant to a written resolution adopted by the Pension and Benefits Committee or by such other means as the Pension and Benefits Committee deems appropriate.

The provisions of the Plan shall be interpreted to comply with applicable requirements of law and, in the event of any change in law, shall be deemed amended to the extent necessary to comply with such change, pending any actual amendment of the Plan for compliance.

In the event the Plan is terminated or changed to exclude a specific group of Eligible Participants and/or their Dependents, the Plan shall pay any claims incurred by a Covered Individual in the affected group before the date of such termination or exclusion to the extent that the Plan provides and to the extent that assets held by the Trust Funds are available (or an applicable Insurance Contract remains in effect). Covered Individuals affected by the termination or exclusion must submit any claims within a reasonable amount of time as determined by the Service Administrator, which shall, in no event be later than the last day for submitting such claims, as specified in the applicable Component SPD or Insurance Contract. The Plan shall not pay any claims incurred on or after the date of Plan termination or exclusion.

8.02 Effect of Plan on Employment.

The Plan shall not be deemed to constitute a contract of employment between the Company and any Participant or to be a consideration or an inducement for the employment of any Participant or Employee. Nothing contained in this Plan shall be deemed to give any Participant or Employee the right to be retained in the service of the Company or to interfere with the right of the Company to discharge any Participant or Employee at any time regardless of the effect that such discharge may have upon him as a Participant in this Plan.

8.03 Provision of Information.

A Covered Individual may be required to submit proof of other coverage, information pertaining to an individual's status as a Dependent, documentation relating to a claim for benefits, and other information necessary for the proper administration of the Plan as the Plan Administrator may require and direct.

8.04 Protected Health Information.

The Plan shall be subject to the applicable requirements relating to the use and disclosure of "protected health information" imposed by HIPAA and to the rules for certain uses and disclosures of protected health information, all as set forth in the HIPAA Appendix to the Plan, which is incorporated herein by reference.

8.05 Applicable Law.

The Plan shall be governed and administered in accordance with the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), and other federal laws and, to the extent not preempted thereby, in accordance with the laws of the State of New Jersey.

To the extent that some benefits under the Plan are provided by an Insurer under an Insurance Contract, the Insurance Contract shall be governed by and administered under ERISA and any other applicable federal laws, and, to the extent not preempted thereby, under such state law as is applicable to the Insurance Contract.

Although coverage and benefits under the Plan are, in most circumstances, intended to be excluded from income for federal income tax purposes, there is no commitment or guarantee that any exclusion for any tax or withholding requirement will apply. By enrolling in the Plan, a Participant agrees to be liable for any tax that may be unpaid with respect to coverage or benefits hereunder and any interest or penalties that may be assessed in connection with the tax.

8.06 Responsibilities of Covered Individuals.

Each Covered Individual shall be responsible for providing the Company or such other entity as the Sponsor may identify with his current address. Any notices required or permitted to be given to a Covered Individual shall be deemed given if sent to the address most recently provided by the Covered Individual and mailed by first class United States mail or by such electronic delivery as may be permitted by applicable law.

8.07 Lost Distributees.

Any benefit payable hereunder shall be deemed forfeited if the Plan is unable to locate the Participant to whom payment is due, provided, however, that such benefit shall be reinstated if a claim is made by the Participant for the forfeited benefit within the time period set forth in the applicable Component SPD.

8.08 Severability.

If any provision of this Plan shall be held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provision, and this Plan shall be construed and enforced as if such provision had not been included.

8.09 Scope of Plan.

The Plan provides solely for the payment of certain health care benefit expenses. All decisions regarding care shall be made by the Covered Individual in consultation with his health care provider.

8.10 Heirs and Assigns.

This Plan shall be binding upon the heirs, executors, administrators, successors, and assigns of all parties, including each Participant and covered Dependent.

8.11 Adopted Children.

Notwithstanding any other provision in the Plan to the contrary, in determining whether any child is a Dependent, a child adopted by an Eligible Participant or placed with an Eligible Participant for adoption shall be treated as a Dependent of such Eligible Participant to the same extent as would a child who is a natural child of such Eligible Participant (without regard to whether the adoption has become final).

8.12 Coordination With State Plans.

The provisions of this Section 8.12 shall apply, notwithstanding any other provision of the Plan to the contrary. The term "State Plan", appearing below, shall mean a plan of any State for medical assistance approved under title XIX of the Social Security Act. The term "State", as used in this Section 8.12, shall have the meaning assigned to such term under section 3(10) of ERISA.

a. Certain Assignments of Rights. The payment of any benefit with respect to a Participant or Dependent under the Plan shall be made in accordance with the terms of any assignment of the rights to such benefit made by, or on behalf of, such Participant or Dependent as required by a State Plan pursuant to section 1912(a)(1)(A) of the Social Security Act (as in effect on the date of the enactment of the Omnibus Budget Reconciliation Act of 1993).

b. Enrollment and Provision of Benefits Without Regard to Medicaid Eligibility. In enrolling an individual as a Participant or Dependent under the Plan, or in determining whether a benefit payment is to be made, or in making a benefit payment to an individual who is a Participant or Dependent, the fact that such individual is eligible for, or is provided, medical assistance under a State Plan shall not be taken into account.

c. Acquisition by States of Rights of Third Parties. To the extent that any payment for medical assistance has been made under a State Plan, in any case in which the Plan has a legal liability to make a benefit payment for items or services constituting medical assistance, the Plan shall make such benefit payment in accordance with the law of any State which provides that the State has acquired the rights of a Participant to such benefit payment for such items or services.

8.13 Component Plans.

This Umbrella Plan Document sets forth terms that apply to various different benefit arrangements described by each of the Component SPDs and Insurance Contracts. The Plan shall be a single plan under this Umbrella Plan Document, for governmental reporting purposes, as applicable to the benefits hereunder, and for other purposes provided that each of the benefits described by a Component SPD shall be administered separately and shall be regarded as a separate plan for purposes of COBRA, certain nondiscrimination testing, the application of exceptions, and certain other purposes under federal law. In that regard, references to the "Plan" throughout this Umbrella Plan Document may refer to the benefits described in a Component SPD instead of or in addition to all of the benefits described in this Johnson & Johnson Group Health Plan.

8.14 No Assignment.

No benefits under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge (collectively, "Assignment") by any person, and any attempt to effect such an Assignment by a Covered Individual or any other person shall be void. The Plan has no obligation to accept any direction from a Covered Individual to make payment to any person, and any payment of benefits under the Plan that is made directly to a health care provider or its agent or representative will be made as a convenience to the Covered Individual and not pursuant to or as constituting an Assignment. All benefits under the Plan shall, to the extent permitted by law, be exempt from the claims of creditors and from all orders, garnishments, executions, and other legal process or proceedings.

8.15 Headings and Captions.

The headings and captions set forth in the Plan are provided for convenience only and shall not limit or extend the meanings of any of the Plan's provisions.

SCHEDULE A

Johnson & Johnson

2023 COMPONENT SPDs AND INSURANCE CONTRACTS

The following is a list of Component SPDs and Insurance Contracts as of January 1, 2023. To the extent that the Sponsor adds any Component SPD or enters into an Insurance Contract under the Plan after that date, it will be deemed incorporated into this Schedule A. To the extent that a Component SPD or an Insurance Contract listed or deemed to be listed below is terminated, it shall be deemed deleted from this Schedule A.

COMPONENT SPDs:

1. General/Administrative Information Plan Details
2. Medical Plan Details
3. Premier HSA Plan Details Supplement
4. HRA Plan Details Supplement
5. Dental Plan Details
6. Vision Care Plan Details
7. Salaried Retiree Vision Plan Details
8. Aetna HMO Plan Details Supplement
9. Harvard-Pilgrim Health Plan HMO Plan Details Supplement
10. Separation Medical Plan Summary Plan Description
11. Salaried Retiree Medical Plan Summary Plan Description Pre-April 1, 1985 Retirees
12. Salaried Retiree Medical Plan Summary Plan Description Post-85
13. Salaried Retiree Dental Program SPD
14. Tobacco Cessation Program Plan Details
15. Prescription Drug Coverage Plan Details Supplement
16. Group PPO Plan Details Supplement

INSURANCE CONTRACTS:

1. Cigna Global (including Dental)
2. HMSA PPO
3. Kaiser of California HMO
4. UnitedHealthcare Insurance Company (Medicare Advantage)
5. Aetna DMO
6. Aetna Retiree Dental

SCHEDULE B

AFFILIATES OF SPONSOR DECLINING COVERAGE

Each Affiliate that is part of the Controlled Group's consumer health care business (i.e., Kenvue Inc. and its affiliates that are part of the consumer health care business, collectively, "Kenvue") shall no longer be a Participating Affiliate as of January 1, 2023, and no employee of Kenvue shall be an Eligible Employee as of such date or, if later, as of such date on which the individual becomes an employee of Kenvue. Except as provided in this Appendix*, no Affiliate that is a "participating affiliate" under the Kenvue Inc. Group Health Plan shall be a Participating Affiliate under this Plan, and no individual who is eligible to participate in the Kenvue Inc. Group Health Plan as an employee of Kenvue shall be an Eligible Employee under this Plan.

No employee whose employment is based on employment with an Affiliate in Puerto Rico shall be an Eligible Employee under this Plan.

*During 2023: (i) employees of Affiliates that are part of Kenvue who enrolled for health benefits as of January 1, 2023 in the Harvard Pilgrim Health Plan ("HPHP Option") shall be covered under the HPHP Option under and in accordance with the terms of this Plan. For purposes of clarity, if and when their employer ceases to be an Affiliate, the coverage provided to such individuals under the HPHP Option will be on account of their status as former employees.